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Access to primary care and public health



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Public health has traditionally considered the main role of health services to be in the relief of sickness, rather than in the improvement of population health.¹ But it is now clear that access to primary care in high-income countries might be of considerable importance in terms of delivering preventive medical interventions and providing a gateway to a health-care system that delivers effective interventions for the major causes of mortality, including cancer and cardiovascular disease. US studies^{2,3} estimate that access to medical care might now contribute several years to life expectancy. This effect on longevity is relevant in the context of gaps in mortality and healthy life expectancy that are associated with deprivation and socioeconomic inequality.⁴

If access to primary care is judged in terms of the availability and use of services,⁵ sizeable inequalities clearly exist in access, with deprived urban areas being underserved.⁶ Shi and colleagues^{7,8} reported several analyses that suggested that an increased supply of primary-care physicians might be associated with improved health and reduced mortality. These ecological associations might be difficult to interpret because of problems related to confounding⁶ and reverse causation.⁹

Researchers are now moving towards a more nuanced understanding of the processes by which people gain access to health care. This understanding goes beyond questions of the aggregate availability and utilisation of services but recognises that individuals' use or non-use of services can at different times be inappropriate. Dixon-Woods and colleagues¹⁰ developed the concept of candidacy, which envisages that an individual's eligibility for service use could be jointly negotiated by service providers and patients. The technical understanding of the provider might not always be consistent with the wants and needs of the patient.

The Article by David Ellis and colleagues¹¹ published in *The Lancet Public Health* investigates one particular kind of non-use of primary care services, missed appointments. The study draws on data from a large population of more than half a million people. The high rate of missed appointments will be of concern to health service managers, with nearly half of the sample missing one or more appointments over a 3 year period. The analysis focuses on the 19% of people who frequently missed appointments (ie, people who

missed two or more appointments over 3 years). Frequently missing appointments showed a strong graded association with deprivation, with patients of low socioeconomic status (Scottish Index of Multiple Deprivation decile 1) more likely to miss multiple appointments than patients of higher socioeconomic status (relative risk ratio [RRR] 2.27, 95% CI 2.22–2.31). After allowing for consultation frequency, men were more likely to miss appointments than women (RRR 1.05, 1.04–1.06). Missed appointments seemed to be more frequent at practices in affluent areas with intermediate waiting times. This was a hypothesis-generating study and some of these associations might need prospective confirmation, but the graded association with deprivation is noteworthy.

Ellis and colleagues¹¹ argue that missing appointments suggests low engagement in health care and could represent a marker for vulnerability and poor health outcomes. These hypotheses merit further investigation by primary-care researchers. There are several reasons why an appointment might be missed. A missed appointment might be less concerning when a consultation is intended to be for an acute illness that could be self-limiting, as compared with a consultation for needed long-term illness care. On some occasions, an individual might seek alternative routes to access through urgent or out-of-hours care rather than wait for an appointment. Sometimes the demands of inflexible employment contracts, or home duties, might prevent people from taking up an appointment. These issues might disproportionately affect low-income groups.

We know that there is a gap in the delivery of preventive medical care, with screening, immunisation and cardiovascular prevention, and dental care, being less frequently accessed by deprived populations.¹² People who smoke might be especially underengaged in preventive activities.¹³ High-risk individuals from low-socioeconomic groups could be more readily encouraged to engage in preventive interventions when they attend the practice for other reasons.¹⁴ Outreach services might also have some success in delivering preventive services at community locations.

Ellis and colleagues¹¹ observe that for health services to be better focused on tackling health inequalities,

future interventions need to take patients' engagement patterns into account. Missed appointments could be used as sentinel events to help identify patterns of help-seeking behaviour, which need to be better understood to address the health needs of deprived populations.

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I declare no competing interests.

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